



Snohomish County Human Resources

Regence Vision Plan Summary (All Employees) Effective 4/1/16

This is only a summary! For more coverage details and limitations refer the [plan booklet](#) or [SBC](#) available online at <http://snohomishcountywa.gov/1029/Vision> or call Regence at 1-800-962-0301 or [Human Resources](#) at 1-425-388-3411 Ex. 0. Monthly premiums are paid in full for [full-time employees](#) that work 35 or more hours per week and [part-time employees](#) pay pro-rated premiums. All plan provisions are calculated on a calendar year basis (January 1st - December 31st).

Important Questions	Regence Vision Plan Group # 10008695
What is the overall <u>deductible</u> ?	No deductible.
Are there other <u>deductibles</u> for specific services?	No.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.
What is not included in the <u>out-of-pocket limit</u> ?	No out of pocket limit.
Does this plan use a <u>network of providers</u> ?	Yes. See www.Regence.com or call 1 (800) 962-0301 for a list of providers. If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.

Are there services this plan does NOT cover?		<p>Yes - This isn't a complete list. Check the plan document for other excluded services.</p> <ul style="list-style-type: none"> • Contact fittings • Cosmetic services and supplies • Fees, taxes, and interest • Medical services • Non-direct patient care • Personal comfort items • Prescription medication • Vision therapy and surgery
Common Medical Event	Services you may need	Your Cost, Limits, and Exceptions
If you visit an eye care provider's office or clinic	Routine vision examination	No charge
	Vision Hardware	<p>No charge up to hardware maximum. Coverage is limited to one routine eye exam per year. Coverage is limited to two lenses per year not to exceed the dollar limit for each lens:</p> <ul style="list-style-type: none"> • \$32 each – single vision lens • \$50 each – bifocal lens • \$61 each – trifocal lens • \$67 each – verilux, verifocal, and blended lens <p>Coverage is limited to one pair of frames every two calendar years not to exceed \$40.</p> <p>Coverage is limited to two contacts or disposable lenses every two calendar years not to exceed the dollar limit for each lens:</p> <ul style="list-style-type: none"> • \$65 each contact lens, or • \$130 for disposable lenses <p>Coverage is limited to either regular lenses or contact lenses, but not both in the same year.</p>